2004 COBRA Medical and Dental Election Form

IF YOU ARE **NOT** MAKING CHANGES TO YOUR COVERAGE FOR 2004, YOU **DO NOT** HAVE TO COMPLETE THIS FORM. IF YOU ARE MAKING CHANGES, COMPLETE THIS FORM AND RETURN IT TO EMPLOYEE BENEFITS WITH A POSTMARK OF NO LATER THAN **NOVEMBER 30, 2003**. REMEMBER THAT ROCKY MOUNTAIN HMO IS NOT BEING OFFERED FOR 2004. YOU MAY ALSO ADD OR DELETE ELIGIBLE DEPENDENTS AT THIS TIME. (See enclosed letter)

Please complete all applicable sections of this form in black or blue ink.

PARTICIPANTS NAME (Name of person electing COBRA)

Last Name	First Name	M.I.	Soc. Sec. No.	
Home Address	City	State	Zip Code	County
Home Telephone	Work Telephone	**Name of Current Medical Plan?**		

Birth Date			Gender
Month	Day	Year	☐ M ☐ F

Are you the former employee? ☐ **Yes** ☐ **No**

If "No" → Former/Present Employee's Name _____

If "No" → Former/Present Employee's SSN _____

MEDICAL PLAN	MEDICAL COVERAGE CATEGORY
Select one medical plan:	**Select one medical coverage category:**
☐ Anthem Liberty EPO	☐ Participant Only
☐ Anthem Centennial PPO	☐ Participant + 1 dependent
☐ Kaiser Permanente HMO	☐ Participant + 2 or more dependents
☐ PacifiCare HMO	
☐ San Luis Valley HMO	

DENTAL PLAN	DENTAL COVERAGE CATEGORY
Select one dental plan:	**Select one dental coverage category:**
☐ BASIC Plan	☐ Participant Only
☐ BASIC PLUS Plan	☐ Participant + 1 dependent
	☐ Participant + 2 or more dependents

MEDICAL and DENTAL PARTICIPANTS (See Dependent Children Age Limitations on reverse of this form.)

List all persons to be covered under COBRA; yourself, spouse, eligible unmarried dependent children.

Name: Last, First, M.I.	Soc. Sec. No.	Relationship to participant	Birth Date Mo/Day/Yr	Check to indicate "Yes" Medical	Check to indicate "Yes" Dental	Gender M	Gender F
Self				☐	☐		
Spouse*				☐	☐		
Dependent Child*				☐	☐		
Dependent Child*				☐	☐		
Dependent Child*				☐	☐		
Dependent Child*				☐	☐		

* Attach the appropriate affidavit form. (See "Affidavits" on the reverse of this form.)

OTHER INSURANCE COVERAGE

If you or any of your covered dependents are eligilble for OTHER insurance benefits, complete the following:

Policyholder Name:	Policy Number:	Name and Address of Other Insurance Carrier
Policyholder Name:	Policy Number:	Name and Address of Other Insurance Carrier

RETURN THIS FORM TO:

Department of Personnel & Administration
Employee Benefits
1313 Sherman Street, Room 114
Denver, CO. 80203

AGREEMENT: (Must be signed and dated)

I hereby certify that the foregoing information made by me is true and that I have read and accept the conditions on the reverse side of this form. I agree to pay the monthly premiums as prescribed by the medical and/or dental carriers. Failure to pay the premiums within the prescribed time will result in cancellation of my dental coverage. I also agree to all of the terms as defined by the dental plan.

Enrollee's Signature: **Date:**

Revised 10/31/2003 Note: Make a copy of this form for yourself. Return this original in the enclosed envelope or mail to the address listed above.

COBRA Medical/Dental Election Form Information

General Information
Review all the information on this form. The health plans offered by the State of Colorado for eligible COBRA participants and their eligible dependents are listed in the "Medical Plan" and "Dental Plan" section on the front of this form. You must complete all applicable sections, sign, and date this form. Make a copy for yourself, then submit this original form to Employee Benefits no later than November 30, 2003.

This form and the additional enrollment materials included, represent the complete enrollment materials package. These materials represent only a summary of the state's group benefit programs. If any discrepancy exists between these materials and the group master contracts, the group master contracts will govern.

Temporary ID
Your xerox copy of this form serves as your temporary identification card and is valid for the first 30 days after your effective date of coverage. If permanent ID card(s) are not received within 30 days after your effective date of coverage, contact the appropriate medical carrier directly at the phone number listed on the bottom of this form.

Dependent Children Age Limitations
Your eligible dependent child(ren) include natural, adopted, foster and stepchildren. Children who are dependent upon you as a major source of financial support are eligible through December 31 of the calendar year in which they turn age 19; or through the end of the month of marriage, or entering military service; or through December 31 of the calendar year in which they are no longer a full-time student, but no longer than the end of the month in which a full-time student turns age 24; or an unmarried child of any age who is medically certified as disabled by the carrier no matter when the disability occurred.

Fraud
It is unlawful for any individual, individual's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's group benefit plans, civil damages, termination of enrollment in any or all of the state's benefit plans, or as provided in regulations, statutes, and written directives.

Appeal Procedures
Your signature on this enrollment form serves as an agreement that you will utilize the appeal procedures established by your medical carrier for resolving disputes. Depending upon the conditions set forth by the medical carrier, this agreement may require utilizing binding arbitration instead of a court trial for dispute resolution.

Affidavits and Legal Documentation
- If you and your eligible dependents, common law spouse, grand and/or foster child(ren), adopted child(ren) and court ordered children are currently enrolled for medical and/or dental benefits for 2003 and have already provided affidavits/legal documentation for the above listed dependents, you will not be required to provide further documentation for the 2004 plan year.
- If you and/or your eligible dependents are enrolling for the first time in the state's medical and/or dental benefits for the 2004 plan year, you must provide all applicable affidavits/legal documentation.

Services & Eligibility
You will be personally responsible for the cost of any services if:
- Such services are determined not to be covered services, and/or;
- You and/or your family members are not eligible for coverage.

Limitations/Exclusions
Some services and/or procedures may be limited or excluded from any of the plans offered by the State of Colorado. Please review the applicable Summary of Plan Benefits for additional information.

Dental
Delta Dental is the carrier for the state's dental program for 2004. There are two dental plans available: the BASIC Plan and the BASIC PLUS Plan. Both plans utilize the same three choice levels of dentists. Your costs will vary depending upon which dental providers are utilized and the plan you select. If you and/or your dependents are currently enrolled in the dental plan through Delta Dental and wish to continue your current dental coverage for plan year 2004, no enrollment form is required. If you are currently enrolled and wish to make changes or if you are not currently enrolled in a dental plan and wish to enroll yourself and any eligible dependents, you must complete and return this form to the dental carrier at the address listed on the front of this form. If you do not enroll in or make any necessary changes at this time, you must wait until the next annual open enrollment period. COBRA participants pay the cost for dental coverage for themselves and eligible dependents ages five and older. Dependents under age five are covered at no premium cost to the COBRA participant for both plans. The COBRA participant and eligible dependents must choose the same dental plan and must stay on the same plan until the next annual open enrollment period. An ID card is not required to receive dental services.

Your Signature On This form:
1. Does not constitute a binding contract or provide any guarantees between COBRA enrollees, eligible dependents, and the State of Colorado.
2. Serves as authorization for the medical and dental carriers to release information to government agencies when required under appropriate federal or state legislation or regulation, or pursuant to legal processes, and to release and obtain medical and dental information to or from other appropriate agencies, providers, and carriers for the purpose of providing necessary health care and administrative services.
3. Serves as an agreement between the COBRA enrollee and the medical and/or dental carriers that you will utilize the appeal procedures established by the medical and/or dental carriers for resolving disputes. Depending upon the conditions set forth by each carrier, this agreement may require utilizing binding arbitration instead of a court trial for dispute resolution.

Anthem BCBS PPO/EPO	1-800-843-5621 or 303-831-2384
PacifiCare HMO	1-800-877-9777
Kaiser Permanente HMO	Denver Metro/Boulder: 303-338-3800
	Colorado Springs: 1-888-681-7878
San Luis Valley HMO	1-800-475-8466 or 1-719-589-3696
Delta Dental	1-800-489-7168